



# **State of Connecticut Office of Health Care Access Letter of Intent Form Form 2030**

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CONNECTICUT OFFICE OF  
HEALTH CARE ACCESS

All Applicants involved with the proposal must be listed for identification purposes. A proposal's Letter of Intent (LOI) form must be submitted prior to a Certificate of Need application submission to OHCA by an Applicant, pursuant to Sections 19a-638 and 19a-639 of the Connecticut General Statutes and Section 19a-643-79 of OHCA's Regulations. Please complete and submit Form 2030 to the Commissioner of the Office of Health Care Access, 410 Capitol Avenue, MS# 13HCA, P.O. Box 340308, Hartford, Connecticut 06134-0308.

## **SECTION I. APPLICANT INFORMATION**

If this proposal has more than two Applicants, please attach a separate sheet, supplying the same information for each additional Applicant in the format presented in the following table.

|   | Applicant One                             | Applicant Two                             |
|---|---|---|
| Full legal name   | Greenwich Hospital                        | Greenwich Ambulatory Surgery Center, LLC  |
| Doing Business As   | Greenwich Hospital                        | Greenwich Ambulatory Surgery Center, LLC  |
| Name of Parent Corporation  | Greenwich Health Care Services, Inc.      | Greenwich Health Care Services, Inc.      |
| Applicant's Mailing Address, if Post Office (PO) Box, include a street mailing address for Certified Mail                                   | 5 Perryridge Road<br>Greenwich, CT 06830  | 5 Perryridge Road<br>Greenwich, CT 06830  |
| What is the Applicant's Status:<br>P for Profit or<br>NP for Nonprofit  | NP  | P   |
| Does the Applicant have Tax Exempt Status?  | Yes                                       | No  |
| Contact Person, including Title/Position:<br>This Individual will be the Applicant's Designee to receive all correspondence in this matter. | Eugene Colucci<br>Chief Financial Officer | Eugene Colucci<br>Chief Financial Officer |
| Contact Person's Mailing Address, if PO Box, include a street mailing address for Certified Mail  | 5 Perryridge Road<br>Greenwich, CT 06830  | 5 Perryridge Road<br>Greenwich, CT 06830  |

|                                   |                     |                     |
|-----------------------------------|---------------------|---------------------|
| Contact Person's Telephone Number | 203-863-3008        | 203-863-3008        |
| Contact Person's Fax Number       | 203-863-2979        | 203-863-2979        |
| Contact Person's e-mail Address   | genec@greenhosp.org | genec@greenhosp.org |

## SECTION II. GENERAL APPLICATION INFORMATION

a. Proposal/Project Title:

Greenwich Ambulatory Surgery Center

b. Type of Proposal, please check all that apply:

☒ Change in Facility (F), Service (S) or Function (Fnc) pursuant to Section 19a-638, C.G.S.:

☒ New (F, S, Fnc)

☐ Replacement

☐ Additional (F, S, Fnc)

☒ Expansion (F, S, Fnc)

☐ Relocation

☐ Service Termination

☐ Bed Addition

☐ Bed Reduction

☐ Change in Ownership/Control

☒ Capital Expenditure/Cost, pursuant to Section 19a-639, C.G.S.:

☒ Project expenditure/cost greater than \$ 3,000,000

☐ Equipment Acquisition

☐ New

☐ Replacement

☐ Major Medical  
(> \$3,000,000)

☐ Imaging

☐ Linear Accelerator

☐ Change in ownership or control, pursuant to Section 19a-639 C.G.S., resulting in a capital expenditure over \$3,000,000

c. Location of proposal, identifying Street Address, Town and Zip Code:

55 Holly Hill Lane, Greenwich CT 06830

- d. List each town this project is intended to serve:  
Please refer to Attachment I for a copy of the service area map
- e. Estimated starting date for the project:  
Upon OHCA approval and completion of construction
- f. Type of project: 11  
 (Fill in the appropriate number(s) from page 7 of this Form)

**Number of Beds (to be completed if changes are proposed)**

| Type | Existing Staffed | Existing Licensed | Proposed Increase or (Decrease) | Proposed Total Licensed |
|------|------------------|-------------------|---------------------------------|-------------------------|
| NA   |                  |                   |                                 |                         |
| NA   |                  |                   |                                 |                         |

**SECTION III. ESTIMATED CAPITAL EXPENDITURE INFORMATION**

- a. Estimated Total Project Cost: \$ 5,500,000
- b. Please provide the following tentative capital expenditure/costs related to the proposal:

|  |                    |
|--|--------------------|
| Medical Equipment Purchases  |                    |
| Major Medical Equipment Purchases<br>Medical/Non-Medical Equipment | \$1,650,000        |
| Non-Medical Equipment Purchases*<br>Working Capital                | \$800,000          |
| Land/Building Purchases  |                    |
| Construction/Renovation  | \$3,050,000        |
| Other (Non-Construction) Specify: _____                            |                    |
| <b>Total Capital Expenditure</b>                                   | <b>\$5,500,000</b> |
| Medical Equipment – Fair Market Value of Leases                    |                    |
| Major Medical Equipment – Fair Market Value of Leases              |                    |
| Non-Medical Equipment – Fair Market Value of Leases*               |                    |
| Fair Market Value of Space – Capital Leases Only                   |                    |
| <b>Total Capital Cost</b>  | <b>\$5,500,000</b> |
| <b>Total Project Cost</b>  |                    |
| Capitalized Financing Costs<br>(Informational Purpose Only)        |                    |

Provide an itemized list of all non-medical equipment to be purchased and leased.

To be determined

If the proposal has a total capital expenditure/cost of \$20,000,000 or more, you may request a Waiver of Public Hearing pursuant to Section 19a-643-45 of OHCA's Regulations? Please check your preference as follows:

☒ No ☐ Yes

If you checked "Yes" above, please check the appropriate box below:

☐ Energy ☐ Fire Safety Code ☐ Non Substantive

If you checked "Yes" to the Waiver of Public Hearing, please provide the following:

- a) Supporting documentation from elected town officials  
(i.e. letter from Mayor's Office).

### Major Medical and/or Imaging Equipment Acquisition:

| Equipment Type   | Name | Model | Number of Units | Cost per unit |
|------------------|------|-------|-----------------|---------------|
| To Be Determined |      |       |                 |               |
| To Be Determined |      |       |                 |               |

Note: Provide a copy of the vendor contract or quotation for the major medical/imaging equipment.

- c. Type of financing or funding source (more than one can be checked):

☒ Applicant's Equity ☐ Capital Lease ☐ Conventional Loan  
☐ Charitable Contributions ☐ Operating Lease ☐ CHEFA Financing  
☐ Funded Depreciation ☐ Grant Funding ☐ Other (specify): \_\_\_\_\_

## SECTION IV. PROJECT DESCRIPTION

**Please see Attachment 2 for project description**

Please provide a description of the proposed project, highlighting each of its important aspects, on at least one, but not more than two separate 8.5" X 11" sheets of paper. At a minimum each of the following items need to be addressed, if applicable.


1. List the types of services are currently being provided. If applicable, provide a copy of each Department of Public Health (DPH) license held by the Applicant.

2. List the types of services are being proposed and what DPH licensure categories will be sought, if applicable.
3. Identify the current population served and who is the target population to be served.
4. Identify any unmet need and describe how this project will fulfill that need.
5. Are there any similar existing service providers in the proposed geographic area?
6. Describe the anticipated effect of this proposal on the health care delivery system in the State of Connecticut.
7. Who will be responsible for providing the service?
8. Who are the current payers of this service and identify any anticipated payer changes when the proposed project becomes operational?

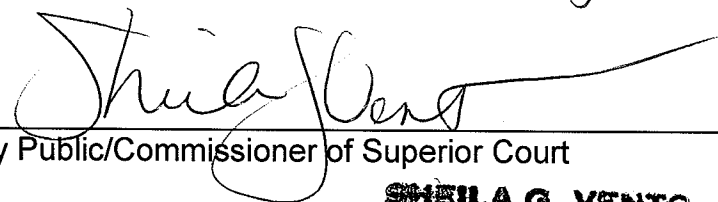
**AFFIDAVIT****To be completed by each Applicant**Applicant: Greenwich Hospital and Greenwich Ambulatory Surgery Center, LLCProject Title: Greenwich Ambulatory Surgery CenterI, Frank A. Corvino, President/CEO  
(Name) (Position – CEO or CFO)

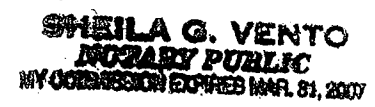
of Greenwich Hospital being duly sworn, depose and state that the  
information provided in this CON Letter of Intent (Form 2030) is true and accurate to  
the best of my knowledge, and that Greenwich Hospital complies with the appropriate and  
(Facility Name)

applicable criteria as set forth in the Sections 19a-630, 19a-637, 19a-638, 19a-639, 19a-486  
and/or 4-181 of the Connecticut General Statutes.

 August 3, 2006  
Signature Date

Subscribed and sworn to before me on August 3, 2006

  
Notary Public/Commissioner of Superior Court

My commission expires: 

## Project Type Listing

Please indicate the number or numbers of types of projects that apply to your request on the line provided on the Letter of Intent Form (Section II, page 2).

### Inpatient

1. Cardiac Services
2. Hospice
3. Maternity
4. Med/ Surg.
5. Pediatrics
6. Rehabilitation Services
7. Transplantation Programs
8. Trauma Centers
9. Behavioral Health (Psychiatric and Substance Abuse Services)
10. Other Inpatient

### Outpatient

11. Ambulatory Surgery Center
12. Birthing Centers
13. Oncology Services
14. Outpatient Rehabilitation Services
15. Paramedics Services
16. Primary Care Clinics
17. Urgent Care Units
18. Behavioral Health (Psychiatric and Substance Abuse Services)
19. MRI
20. CT Scanner
21. PET Scanner
22. PET/CT Scanner
23. Other Imaging Services
24. Lithotripsy
25. Other Medical Equipment
26. Mobile Services
27. Other Outpatient
28. Central Services Facility
29. Occupational Health

### Non-Clinical

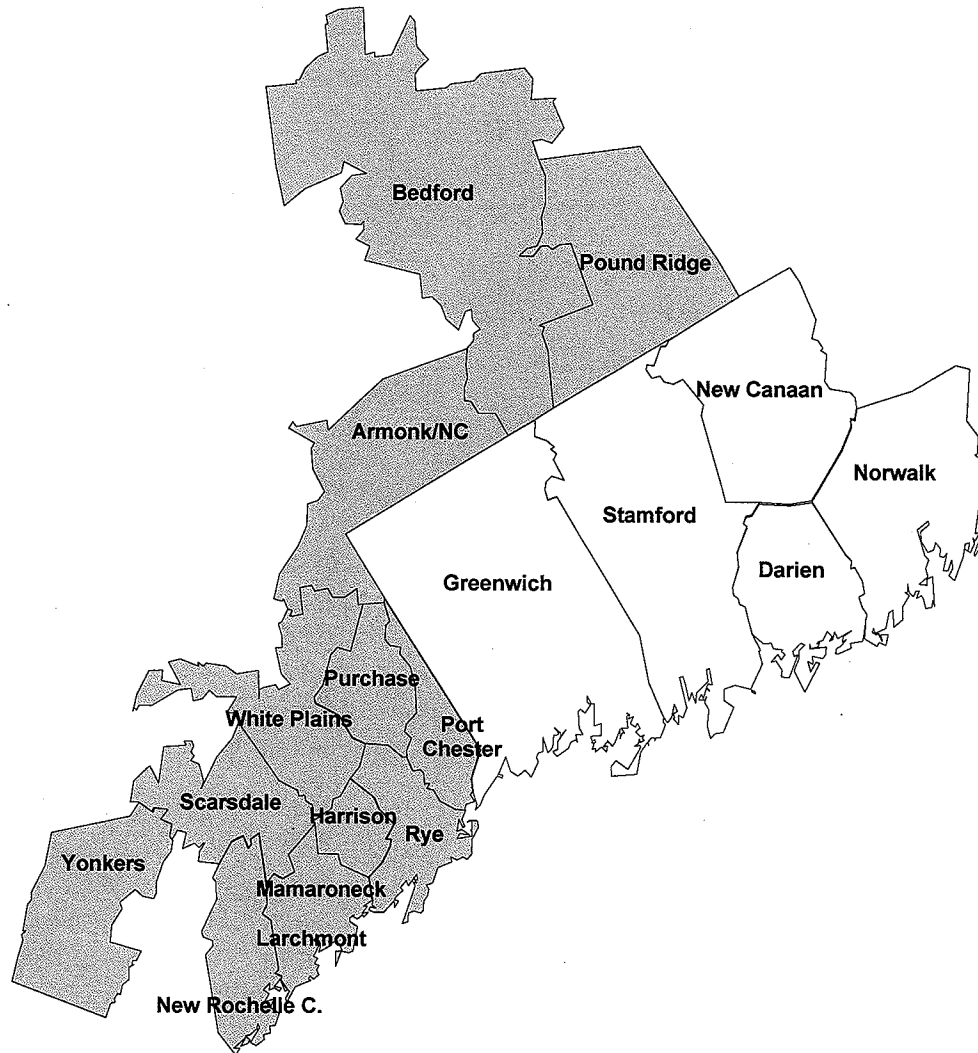
30. Facility Development
31. Non-Medical Equipment
32. Land and Building Acquisitions
33. Organizational Structure (Mergers, Acquisitions, Affiliations, and Changes in Ownership)
34. Renovations
35. Other Non-Clinical



# **Attachment I**

## **Service Area Map**

## Service Area Map



# **Attachment II**

## **Project Description**

## Project Description

A member of the Yale New Haven Health System, Greenwich Hospital is a community teaching hospital, affiliated with the Yale University School of Medicine. Greenwich Hospital is a progressive medical center offering a wide range of medical, surgical, diagnostic and preventive programs. Greenwich Hospital is committed to providing the highest quality of care to the communities it serves. Greenwich Hospital's Department of Public Health License is presented in Attachment III.

With this Letter of Intent, Greenwich Hospital and Greenwich Ambulatory Surgery Center, LLC are seeking approval to establish and operate an ambulatory surgery center located near the Hospital.

Greenwich Hospital offers a broad array of surgical services which are currently provided on the main Hospital campus at 5 Perryridge Road in Greenwich. The Hospital has experienced growth in surgical services over the past several years. It is expected that the Hospital will reach capacity in the near future, limiting the Hospital's ability to meet demand for inpatient and outpatient surgical services from the current medical staff. In addition, the hospital's medical staff is growing which will create a further need for additional capacity for outpatient surgical services.

In order to meet this growing demand for surgical services and offer easily accessible, convenient services, Greenwich Hospital and Greenwich Ambulatory Surgery Center, LLC propose to open the ambulatory surgery center. The ambulatory surgery center will provide access to additional outpatient surgical services in a location convenient to the expanding patient base, which will provide additional needed capacity for inpatient surgeries at the Hospital. As well, the ambulatory surgery center will meet the evolving needs of patients in the service area. The trend, both nationally and locally, is for surgery to be provided as an outpatient as opposed to an inpatient service. The proposed ambulatory surgery center will be the best option to address this trend. The ambulatory surgery center is a cost effective solution to increase capacity while not disrupting services available to patients as well as provide services in an optimal setting.

In an effort to work cooperatively with our physicians and provide the best possible care for our patients, Greenwich Hospital is establishing Greenwich Ambulatory Surgery Center, LLC, and possibly additional LLCs, to provide the ambulatory surgery services and permit physician investment in these services. Greenwich Hospital will either provide the surgical services directly or will control the LLC that operates the surgery center.

The proposed ambulatory surgery center will be located at 55 Holly Hill Lane, Greenwich, in a medical building currently housing several physician practices and hospital outpatient services. The location is owned by an affiliate of Greenwich Hospital. Greenwich Hospital will perform the fit-out of the space and lease the same space to the operating LLC (s). The ambulatory surgery center will occupy approximately 12,000 square feet of space at this location. There will be four operating rooms located at the center as well as recovery areas, administrative and support space. Pre-admission services as well as laboratory work solely to support the operations of the ambulatory surgery center will be offered on-site.

The ambulatory surgery center will not impact other area providers. Greenwich Hospital and Greenwich Ambulatory Surgery Center, LLC will provide the proposed services to meet the growing needs of the population served by the Hospital. The payer source and target market would remain unchanged for Greenwich Hospital. There are no other ambulatory surgery centers in the immediate area.

The addition of an ambulatory surgery center to Greenwich Hospital's current complement of services will enhance the State of Connecticut health care delivery system. Greenwich Hospital and Greenwich Ambulatory Surgery Center, LLC will be able to provide patients with state-of-the-art, easily accessible, excellent quality care when they need it, as soon as they need it.

## **Attachment III**

# **Department of Public Health License**

**STATE OF CONNECTICUT**  
**Department of Public Health**  
**LICENSE**  
**License No. 0045**

**General Hospital**

In accordance with the provisions of the General Statutes of Connecticut Section 19a-493:

Greenwich Hospital of Greenwich, CT, d/b/a Greenwich Hospital is hereby licensed to maintain and operate a General Hospital.

Greenwich Hospital is located at 5 Perryridge Rd, Greenwich, CT 06830

The maximum number of beds shall not exceed at any time:

32 Bassinets

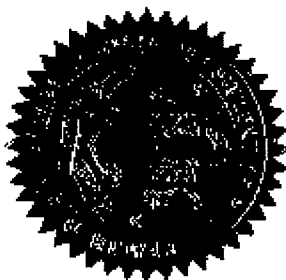
174 General Hospital beds

This license expires September 30, 2007 and may be revoked for cause at any time.

Dated at Hartford, Connecticut, October 1, 2005. RENEWAL

**Satellites**

The Endoscopy Center of Greenwich Hospital, 500 West Putnam Avenue, Greenwich, CT  
100 Cy 1000 Campus, 51 Holly Hill, Greenwich, CT



*J Robert Galvin M.D., M.P.H.*

J Robert Galvin, M.D., M.P.H.,  
Commissioner